



American Dental Association
www.ada.org

American Dental Association

— State and Community Models for Improving Access to Dental Care for the Underserved—A White Paper

October 2004

Vision Statement

With each passing year, science uncovers more evidence of the critical importance of oral health to overall health. Early diagnosis, preventive treatments and early intervention can prevent or halt the progress of most oral diseases-conditions that, when left untreated, can have painful, disfiguring and lasting negative health consequences. Yet millions of American children and adults lack regular access to routine dental care, and many of them suffer needlessly with disease that inevitably results. Oral health access problems cut across economic, geographic and ethnographic lines. Racial and ethnic minorities, people with disabilities, and those from low-income families are especially hard hit.

The nation's dentists have long sought to stem and turn the tide of untreated disease, as individuals, through their local, state and national dental societies, and through other community organizations. Dentists alone cannot bring about the profound change needed to correct the gross disparities in access to oral health care. But dentistry must provide the leadership that initiates change, or it will not occur.

Ultimately, education and prevention will be the linchpins in eliminating, or at least minimizing, untreated dental disease. The day that we as a nation decide to provide oral health education to families of newborns, public health measures such as community water fluoridation, and regular dental visits to every American will mark the birth of the first generation that could grow up essentially free of dental disease. Until that occurs, the nation will be challenged to meet the needs for preventive and restorative care among large numbers of Americans who do not have dental coverage, cannot afford care or face other challenges that prohibit them from seeking regular oral care and dental visits.

The American Dental Association and its members will continue working with policymakers to establish programs and services that improve access to oral health care. We urge the nation to join us in:

- Rejecting programs and policies that marginalize oral health, and instead supporting those that recognize that oral health is integral to overall health and can affect a person's self esteem, ability to learn and employability.
- Acknowledging that the degree of oral health disparities and the extent and severity of untreated dental disease-especially among underserved children-is unacceptable.
- Committing, through both advocacy and direct action, to identify and implement commonsense, market-based solutions that capitalize on the inherent strengths of the American dental care system and that make it possible for all Americans, regardless of their financial, geographic, physical or other special circumstances, to experience optimal oral health care.

American Dental Association. *State and Community Models for Improving Access to Dental Care For the Underserved—A White Paper*. Chicago: American Dental Association: 2004.

Background

The Need to Improve Access to Oral Health

As U.S. Surgeon General David Satcher noted in his 2000 landmark report *Oral Health in America*¹, while most Americans have access to and receive oral health care, the burden of oral disease continues to spread unevenly throughout the population. Oral health access problems cut across socioeconomic and geographic lines. Racial and ethnic minorities, people with disabilities and low-income families are especially hard hit.

The Surgeon General reported that dental caries (tooth decay) is the most common chronic disease of childhood—five times as common as asthma, and low-income children suffer twice as much from dental caries as children who are more affluent. In fact, fewer than one in five underserved children sees a dentist in any given year, according to data collected by the Centers for Medicare and Medicaid Services. These children cannot eat well, resulting in poorer health; they cannot study, reducing their performance in school; and they do not want to smile. Their self-esteem is negatively affected. They grow up to be adults who continue to be affected by the oral disease they faced in their younger years—often at a disadvantage in the job market due to poor oral health and appearance.

There is no shortage of shocking statistics or distressing anecdotes to describe the access problems faced by thousands of underserved children, adults, low-income elderly and others who face complex medical and other special needs. It is critical for policymakers at the federal and state level to join with the dental community and acknowledge that for every person, oral health is integral to general health and well-being – you are not healthy without good oral health.

Through current oral health research, scientists are discovering that the connection between oral health and general health might be even stronger than first realized—with suspected associations between certain oral diseases and systemic diseases and conditions, including diabetes, cardiovascular disease, stroke and pre-term low birthweight babies.

Achieving Healthy People 2010 Goals – Oral Health

In 2000, the U.S. Department of Health and Human Services released *Healthy People 2010*, a comprehensive set of public health priorities to address disease prevention and health promotion objectives for the nation. *Healthy People 2010* includes 22 oral health objectives,² to be used as measures of success of federally funded public oral health programs and for developing state, community and private initiatives toward improving the public's oral health. The following provides a sample of the American Dental Association's efforts to achieve the goals of *Healthy People 2010*:

- Give Kids A Smile project, a national, annual event held each February where dentists provide free oral health care services to more than a million low-income children across the country while highlighting the ongoing challenges that many disadvantaged children face in accessing dental care.
 - An oral cancer awareness campaign in collaboration with CDx Laboratories to promote the importance of early detection of oral cancer to dental professionals and the public. The ADA and the U.S. Public Health Service collaborated on a public service announcement featuring
- Dr. Richard Carmona, U.S. Surgeon General, on oral cancer recognition and early detection.

 - Management of a National Cancer Institute Grant, “Behavior Modification, Dentists and Cancer Control.” This unique grant provides an opportunity to assess the success of a national continuing education program designed to increase dentists’ efforts to detect oral cancer at its earliest stages and provide tobacco use cessation counseling.

¹ <http://www.nidcr.nih.gov/NR/rdonlyres/C133CA2D-4A12-4746-A856-3F778DEA49F7/0/NationalCallToAction.pdf>. U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

² <http://www.healthypeople.gov>. U.S. Department of Health and Human Services. *Healthy People 2010*. 2nd ed. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

- Promotion of community water fluoridation and support for state and local fluoridation initiatives. In the past five years (1999 through 2003), more than 130 U.S. communities have voted to adopt fluoridation.
 - Initiation of a national campaign in collaboration with Colgate, titled “ADA/Colgate Diabetes and Gum Disease Campaign.” The dental education project is targeted at both dental professionals and the public to provide a greater understanding about the unique oral health treatment needs of diabetic patients.
- Establishment of the Institute for Diversity in Leadership, a professional growth program targeted at women and minority dentists who have traditionally been under-represented in leadership roles. The goal is to provide a diverse group of dentists with leadership skills to enhance their ability to be effective leaders within the dental profession and their communities.
 - Establishment of the National Campaign for Dentistry, a program designed to attract qualified students into the dental profession (as dentists and allied dental personnel), particularly underrepresented minority students.

In May 2003, the Office of the Surgeon General, under the leadership of Dr. Carmona, again reemphasized the importance of these objectives, extending an invitation to outside organizations to develop a national *Call to Action*³ on oral health access. The ADA is an active partner in this collaboration, serving as a partnership network member.

U.S. Health and Human Services Secretary Tommy Thompson launched a campaign in 2003 called “Steps to a HealthierUS,”⁴ with the goal of helping Americans live longer, better and healthier lives through disease prevention and by adopting healthy lifestyles. Unfortunately, this campaign does not specifically address oral health; however, it addresses key diseases and health factors associated with oral health—diabetes prevention, obesity prevention, heart disease and stroke prevention, and cancer prevention. The campaign also seeks to target health disparities. To elevate the importance of oral health as part of the Secretary's campaign, the ADA participated in the 2004 Steps summit to address the importance of oral cancer awareness and prevention, as part of any cancer control and prevention initiative.

Barriers to Care

As a result of numerous national reports and conferences,^{5,6,7,8,9} the barriers to accessing dental care across the states and the causes of dentists’ reluctance to participate in public programs have largely been identified. These barriers include:

- Low Medicaid reimbursement rates that are often less than what it costs dentists to provide care.
 - Excessive paperwork and other billing and administrative complexities.
 - Lack of case management to assist patients in receiving care, which can lead to high rates of broken appointments.
- Poor oral health literacy and awareness about the importance of oral health.
 - The distribution or location of dentists within some states and local communities.

³ <http://www.surgeongeneral.gov/topics/oralhealth/>. U.S. Department of Health and Human Services. *A National Call to Action to Promote Oral Health*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention and the National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303, May 2003.

⁴ <http://www.healthierus.gov/steps/>. U.S. Department of Health and Human Services. *Steps to A Healthier US*. Washington, DC: U.S. Department of Health and Human Services, Office of Public Health and Science, Office of Disease Prevention and Health Promotion. 2003-2004.

⁵ <http://www.gao.gov/new.items/he00072.pdf>. *Oral Health: Dental Disease Is a Chronic Problem Among Low-Income Populations*. April 2000. GAO/HEHS-00-72. United States General Accounting Office.

⁶ <http://www.gao.gov/new.items/he00149.pdf>. *Oral Health: Factors contributing to low use of dental services by low-income populations*. September 2000. GAO/HEHS-00-149. United States General Accounting Office.

⁷ <http://www.oig.hhs.gov/oei/reports/oei-09-93-00240.pdf>. *Children's dental services under Medicaid: Access and Utilization*. OEI-09-93-00240. April 1996. Office of the Inspector General.

⁸ <http://www.mchoralhealth.org/PDFs/Ohproceedings.pdf>. *Building partnerships to improve children's access to Medicaid oral health services: National conference proceedings*. June 2-4, 1998. National Center for Education in Maternal and Child Health.

⁹ <http://www.nga.org>. National Governors Association, Center for Best Practices. *State Efforts to Improve Children's Oral Health*. Washington, D.C.: 2002.

Adequate Reimbursement that Mirrors Market-Based Fees

One of the most critical strategies for improving access to oral health care is for states to increase Medicaid rates for all dental procedures to more closely mirror the marketplace. Reimbursing dentists at significantly less than it often costs them to provide care is not conducive to dentist participation in public programs. In some states, inadequate fee adjustments perpetuate inadequate reimbursement levels—sometimes for as many as 15 or 20 years with rates not even adjusted to meet inflation. Several states have faced lawsuits over low reimbursement rates from patient advocacy organizations as well as dentists, with most being resolved favorably for the plaintiffs through settlements. Lawsuits tend to focus on a state's noncompliance with Medicaid statutes, including requirements that fees be adequate to enroll an appropriate number of providers to ensure adequate care can be provided (42 U.S.C. § 1396a(a)(30)(A)).^{10 11}

For most states, inadequate reimbursement schedules are based on a fundamentally flawed application of the concept of “Usual, Customary and Reasonable” (UCR) fees that differs from the commercial dental benefits sector.¹² These state programs establish their reimbursement schedules by averaging the fees submitted by participating dentists for services they provided to Medicaid enrollees in a prior fiscal year and establishing a Medicaid claims database. This approach does not provide a valid reflection of market-based dental fees for several reasons, including the fact that most Medicaid programs do not update fee schedules regularly to account for inflation or other market factors. Within a few years, the gap between Medicaid payments and dentist charges becomes wide. During fiscally challenging years, state budget cuts exacerbate the problem of inadequate reimbursement rates, particularly when state policymakers selectively or uniformly reduce dental reimbursement rates or eliminate adult dental coverage as a means to lower Medicaid expenditures.

The ADA believes that states should work to establish competitive Medicaid reimbursement rates to effectively improve the program. Based on the experience of some states that have improved access to oral health care for the underserved, increasing reimbursement to the 75th percentile of market rates may be necessary. The 75th percentile fee level for a particular area indicates that 75 percent of dentists in that area report that they charge that amount or less for a particular service. In those states that have increased Medicaid fees to achieve or come close to this goal (e.g., South Carolina, Georgia, Tennessee), there has been a marked increase in dentists agreeing to participate in the Medicaid program and in the ability of Medicaid beneficiaries to secure access to care.

Administrative Programs that Mirror the Private Sector

Burdensome administrative requirements (e.g., prior authorization, complex billing procedures, determining patient eligibility) further deter dentist participation in public programs. Medicaid programs, for example, are often administered in a much more complex, unfamiliar and unusual manner than private and commercial dental benefit programs.¹³

State agencies are employing a variety of strategies to improve the management and administration of public programs:

- Operating state-run, fee-for-service programs with improved resources and administrative simplification.
- Contracting with one or more vendors with individual responsibilities for addressing specific administrative and operational components of a program (e.g., provider recruitment and retention).¹⁴
- Contracting with a single vendor that reimburses on a fee-for-service basis, has or is able to build an active participating dental network, and can administer the complete administrative functions and daily operations of a public program.

¹⁰ <http://www.healthlaw.org/pubs/dentaldocket.html>. National Health Law Program. *Docket of Medicaid Cases Filed to Improve Dental Access*. October 19, 2001.

¹¹ Sfikas, Peter M., JD. Journal of the American Dental Association. *Supreme Court Opens Door to Enforcement of Medicaid Consent Decrees*. March 2004.

¹² <http://www.ada.org>. American Dental Association. “Medicaid Reimbursement – Using Marketplace Principles to Increase Access to Dental Services.” (9 regional versions) *Innovations in Dental Medicaid*. Chicago: American Dental Association: 2004.

¹³ <http://www.ada.org>. American Dental Association. “Medicaid Program Administration.” *Innovations in Dental Medicaid*. Chicago: American Dental Association: 2004.

¹⁴ Ibid.

Effective Provider/Patient Outreach and Care Coordination

Effective case management and provider and patient education programs are also important in the effort to increase dentist participation in public programs and improve utilization of services. These programs include:

- Outreach to the underserved about eligibility for dental coverage programs and the availability of dental services.
- Assistance with locating participating dental providers.
- Enhanced provider outreach to educate dentists on how to work with Medicaid and other state public assistance agencies, and how to work with patients who receive public assistance (e.g., ensure cultural awareness and sensitivity).
- Ensuring that patients are continuously eligible for public assistance programs– for at least a six-to-twelve month period.
- Health promotion and improved oral health literacy.
- Transportation and other assistance programs (e.g., patient notification/appointment reminder programs) to address missed appointments.¹⁵

Distribution of Dentists

According to ADA survey statistics, 90 percent of the nation's dentists are private practitioners in small practice settings. Dentists tend to locate their offices where there is likely to be an adequate number of patients who will demand and be able to pay for services.¹⁶ Some areas, both urban and non-urban, do not have access to convenient dental services because of several factors, including what dentists perceive to be a lack of demand for services. The dental profession is deeply concerned about deficits in access to care. Efforts must be made to adjust programs and create practice opportunities to attract dentists to areas in need.

Models for reform that have succeeded in improving dentist participation in public programs, by addressing the barriers outlined above, have also begun to address distribution concerns (e.g., Michigan and Tennessee). Programmatic reforms have reduced the distance patients have to travel to find a dentist who is accepting new public assistance patients because more dentists are willing and able to participate in their home communities as a result of these reforms. While there are communities that face additional barriers in attracting dentists, particularly due to geographical challenges, certain state models that address barriers inherent in public programs have demonstrated that the existing dental network can often be sufficient to address the oral health needs of a community in need.

Public Health Interventions and Safety Net Delivery Systems

Programs that emphasize disease prevention are important for improving the public's health (e.g., community water fluoridation, sealant programs, school-linked health education and care programs). However, such programs are not a substitute for comprehensive care provided by dentists to diagnose and treat disease.

The federal Health Resources and Services Administration (HRSA), in assessing the need for dental practitioners based on a population-to-dentist ratio, has designated 2,112 dental health professional shortage areas (DHPSAs) across the United States. DHPSA criteria were established in the years 1965-1980, and recent studies provide recommendations for revising these criteria.¹⁷ In response to 2002 federal legislation requesting a review and possible revision to criteria that identify health professional shortage areas, HRSA has contracted with the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill to reevaluate the DHPSA methodology and issue recommendations for improvement. The ADA believes that criteria to designate these areas should take several factors into consideration, including the demand and need characteristics of the persons living in areas considered to have a shortage of dentists, as well as the distribution of

¹⁵ <http://www.ada.org>. American Dental Association. “Enhancing Dental Medicaid Outreach and Care Coordination.” *Innovations in Dental Medicaid*. Chicago: American Dental Association: 2004.

¹⁶ Demand is being defined as people seeking services for whom there is a ready mechanism to pay for services, including private funds, dental benefits or adequately funded public assistance programs.

¹⁷ Orlans, Mertz, Grumbach. UCSF Center to Address Disparities in Children's Oral Health. UCSF Center for California Health Workforce Studies. Dental Health Professional Shortage Area Methodology: A Critical Review. October 2002.

dentists and the geographic areas from which they draw their patients. Largely due to the unavailability of relevant local data, the ADA believes the current HRSA criteria are much too inexact and general to address these important distinctions.

Federal law requires all community health center applicants, as a condition of receiving federal funding, to demonstrate that they will provide comprehensive dental services to the population served by the facility either on site or through a contractual arrangement. These requirements have not significantly improved access to dental services for the underserved. The dental safety net through community health centers remains quite small, and retaining dental providers through traditional means (e.g., hiring dentists and dental auxiliaries on staff) is a challenge.¹⁸

Nonetheless, it is important to note that dental clinics (government funded, private and non-profit) can have a critical role in communities that are geographically challenged in attracting private dental practices. In some communities these clinics may be the only resource available for dental care, and often times they are overwhelmed. Dentists who dedicate their careers to work in these clinics demonstrate their commitment to improving access to care for the underserved. To attract and retain more dentists to work in these facilities, they must be paid competitive incomes. Likewise, identifying new opportunities to have the safety-net clinics work in partnerships with private practitioners will only further help to improve access to dental care for those in underserved locations.

Dental schools also are key to improving the availability of dental services for communities. These institutions educate and train students and residents in community-based settings to help them understand and address the needs of the underserved.

Dental Utilization and Outcomes

Data from the Medical Expenditure Panel Survey (MEPS),¹⁹ indicate that children under 200 percent of poverty are less likely to utilize dental services than are children above 200 percent of poverty.

Table 1; Dental visits by children 2 to 18 years old, by poverty level - 2001 MEPS

Poverty Level	% with a Dental Visit	Number	Percent of Population
< 100% FPL	28.7%	11,154,372	16.2%
100 to < 125%	26.4%	3,665,657	5.3%
125 to < 200%	38.1%	11,144,188	16.2%
200 to <400%	49.4%	22,506,398	32.7%
>= 400%	65.2%	20,357,458	29.6%

In 2000, the Health Care Financing Administration (since renamed the Centers for Medicare and Medicaid Services) issued a letter to state Medicaid programs,²⁰ outlining a two-tiered approach for assessing state efforts to ensure children eligible for Medicaid were receiving dental care at appropriate utilization levels. The agency stated that its highest priority would be to conduct reviews of states where the proportion of Medicaid-enrolled children who received a dental visit in the preceding year was 30 percent or less. The agency would then conduct reviews of states where the proportion of Medicaid-enrolled children receiving an annual dental visit was more than 30 percent, but less than 50 percent. The agency explained that such reviews are designed to assure that children eligible for Medicaid have comparable access to services as children in the general population.

States that have increased dental utilization of services within public programs have seen overall program costs increase. Information from states that have implemented programmatic changes, including increased Medicaid fees and administrative improvements, suggest three stages of changes within utilization of dental services: (1) Medicaid children already being seen receive more services; (2) participating dentists begin to see more Medicaid children; (3) more dentists participate in Medicaid.

¹⁸ Bolin, Kenneth A., DDS, MPH; Shulman, Jay D., DMD, MA, MSPH. *Nationwide Survey of Dentist Recruitment and Salaries in Community Health Centers*. Journal of Health Care for the Poor and Underserved. 15 (2004): 161-169.

¹⁹ MEPS is a national survey conducted by the federal Agency for Healthcare Research and Quality.

²⁰ <http://www.cms.gov/states/letters/smd118a1.pdf>. Westmoreland, T. HCFA State Medicaid Director Letter of January 18, 2001, #01-010, *Access of low-income children to necessary dental services*.

When more dentists participate and more patients utilize services, program costs increase. Over time, individual beneficiary health care costs may be reduced as dental services are made available and are utilized and health improves. However, overall program costs will most likely continue to be greater than prior to the state's reform efforts, partly due to fluctuations in the enrollment of the Medicaid population.

Charitable Care

In the absence of effective public health financing programs, many state dental societies have joined with other community partners to sponsor voluntary programs to deliver free or discounted oral health care to underserved children.²¹ A 2004 internal ADA survey²² of state dental society presidents-elect identified 529 regional and local charitable programs, such as free clinics and referral programs, operating throughout the country. According to the *ADA's 2000 Survey of Current Issues in Dentistry*, 74.3 percent of private practice dentists provided services free of charge or at a reduced rate to one or more groups (e.g., homebound, handicapped, low income). A total national estimate of the value of this care was \$1.25 billion, or \$8,234 per dentist.

In 2003, the ADA launched what has become an annual, national program, hosting events around the country to reach out to underserved communities, providing a day of free oral health care services through a program called "Give Kids A Smile" (GKAS). This program helps to educate the public and state and local policymakers about the importance of oral health care while providing needed and overdue care to large numbers of underserved children. In 2004, approximately one million children received free dental education, screening, preventive or restorative care from 38,000 dentists and dental staff volunteers.

Through GKAS and many other voluntary events, dentists demonstrate that they will create innovative ways to reach out to these underserved children. However, altruism alone will not fundamentally provide sustained access to care for the millions in need.

²¹ Jasek, Klyop, Landman. *Advancing Dentists Charitable Dental Initiatives – An American Dental Association Perspective*. Journal of the American College of Dentists. Volume 71. November 1, 2004.

²² American Dental Association, Survey Center, 2004 Access Programs Survey.

Introduction

The ADA's efforts to improve access to care for the underserved have largely focused on children served by Medicaid, because significant oral health disparities exist for this population despite the fact that federal law requires states to cover dental services for Medicaid-eligible children through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The ADA is also concerned about access to dental care for adults served by public programs, particularly the low-income elderly. Providing publicly funded dental benefits to these beneficiaries is within the discretion of the states, and most states provide only minimal emergency dental treatment for adults.

In September 2003, the ADA published the report, *State Innovations to Improve Dental Access for Low-Income Children: A Compendium*²³ to capture the multitude of innovations states have pursued to improve access to care. Through unique public-private partnerships, some states have developed programs that can serve as models for providing dental services to low-income children or others served by public programs. Often, these homegrown programs show a remarkable return on a minimal investment.

In follow-up to the *Compendium*, the ADA published a series of policy briefs²⁴ in March 2004 to highlight specific innovative programs states have established to address key barriers associated with access-to-care within the Medicaid program. The policy briefs address increasing access through collaborative partnerships, using marketplace principles to increase access to services, improving Medicaid program administration, and improving Medicaid outreach and care coordination.

This paper is the next step in the ADA's efforts to assist states as they consider how to strengthen their public programs to improve access to dental care for underserved populations. The Association has identified five access-to-care model programs for states to consider in an effort to provide a blueprint for change. *Three* models identify current state initiatives to implement fundamental reforms to Medicaid programs-Michigan, Tennessee and Alabama. *Two* models focus on innovative, community-based health care safety net proposals-Connecticut and Vermont. While the three state-based models focus on improving access for children under Medicaid, states could utilize the same models to expand access to care for additional Medicaid populations (e.g., adults or the elderly). The two community-based models focus on improving access to care for all—including those served by public programs and the uninsured.

The ADA realizes that for effective change to occur, each state and community must develop a program that is appropriate to address its geographic and demographic needs.

The first three models in this paper are meant to provide all stakeholders with a concise overview of state programs that attempt to take a comprehensive approach toward improving dentists' participation in public programs and enhancing access to and utilization of services. The last two models serve as examples of community-focused efforts to increase access by expanding dental delivery sites. These community models would serve to compliment more comprehensive state reform proposals, such as the first three models outlined in this paper.

Each model was selected after a careful examination of state access innovations through research and publication of the ADA *State Innovations Compendium*. In December 2003, the ADA also requested that representatives of the dental public health, private dental practice, dental insurance industry, state dental director and state legislative communities submit descriptions of what they believe to be model access programs. One of the key success factors of the models selected is collaboration among all stakeholders. Dentists and dental societies cannot design good programs without other key stakeholders; and local and state governmental agencies and community organizations cannot design sound programs without dentists and dental societies. Working together in a true collaboration that considers all aspects of the complex issues, the models outlined demonstrate that improvements are possible.

²³ <http://www.prnewswire.com/mnr/ada/11207/>. American Dental Association. *State Innovations to Improve Access to Oral Health Care for Low-Income Children: A Compendium*. Chicago: American Dental Association: 2003.

²⁴ <http://www.ada.org>. American Dental Association. *Innovations in Dental Medicaid*. Chicago: American Dental Association: 2004.

The ADA realizes that many additional innovations exist at the state and community level to improve access to oral health care. Readers should not interpret the focus of this paper as an attempt to diminish the importance of other approaches or to discourage ongoing creative development of new ideas.

The following outlines a template for the three state-based models and two community-focused, safety net models, providing policymakers an overview of successful efforts to enhance dentist participation in public programs, and as a result, improve utilization of dental services. The ADA does not intend to provide the reader quantitative comparisons of the state and community models from what is presented in this paper. Rather, the Association's intent is to provide a starting point for further investigation and consideration of programs that could be implemented by others as they work to improve access to care in their states and communities.

State Access Reform - Model 1

Medicaid Fee-for-Service Program Administered by a Single Vendor

Introduction

A relatively new and innovative model state approach toward administering a fee-for-service children's dental Medicaid program is to provide benefits through a single commercial dental plan that has a robust network of dental providers. This model employs a public-private partnership between a state Medicaid program and a commercial dental plan to deliver care to low-income children under the age of 21.

Dental reimbursements for the services provided through the demonstration program are identical to those in the commercial dental plan. All administrative transactions for the program are handled through the dental plan in the same manner as those used with its other dental plans. Children can receive care from any dentist within the demonstration counties if the dentist participates in the dental plan. Covered dental procedures under the program are paid at competitive market rates, with no patient co-payment requirements.

Sample Program

In 1998, Michigan established a State Children's Health Insurance Program, called MICHild. This program includes a comprehensive dental benefit and private dental carriers administer the program--Delta Dental Plan of Michigan (DDPM) being one of the statewide dental carriers. Over the years, MICHild demonstrated that this type of state-private dental partnership is an appropriate approach to securing access to care among the state's low-income children. DDPM reports that in the first year, the proportion of MICHild enrollees who had at least one dental visit was nearly identical to the proportion of privately insured children who had had at least one dental visit in the state.

As a result of the success of the MICHild dental component and the need to improve access to dental services for children served by the state Medicaid program, Michigan's Medical Services Administration (MSA), which administers the state Medicaid program, chose to begin a demonstration program that would model the administration and organization of the MICHild dental program. The Michigan legislature appropriated funds to specifically address the lack of oral health services for Medicaid beneficiaries, especially those in rural areas. One of the programs funded for this purpose is the Healthy Kids Dental (HKD) program.

The HKD program called for the Michigan Department of Community Health to contract with a statewide dental insurance carrier that would administer the Medicaid dental benefit within specific counties as a demonstration. The Department issued a bulletin announcing the program and called for any statewide dental carrier who could meet the established criteria to submit a proposal. Delta Dental Plan of Michigan was the only carrier to respond to the request.

On May 1, 2000, the state automatically converted the dental coverage of all Medicaid-enrolled children (younger than 21 years of age) residing in 22 of Michigan's 83 counties from traditional Medicaid to HKD. The counties selected are geographically rural, and at the time, the population had limited access to dental care. Children in 18 of the 22 counties, representing approximately two-thirds of the total HKD enrollment, were enrolled in DDPM's DeltaPremier dental program, which provides fee-for-service reimbursement to any DeltaPremier dentist in the state. Children in the remaining four counties, representing approximately one-third of the HKD enrollment, were enrolled in DDPM's preferred provider program, referred to as DeltaPreferred Option, or DPO.

In developing these programs, both the state and Delta Dental compared the MICHild networks and the Medicaid dentist enrollment. Those counties that had a DPO network greater than 20 percent of the Medicaid-enrolled dentists were chosen as DPO network counties. The same counties that were contracted as MICHild DPO networks became Healthy Kids Dental DPO

networks. The mix of Premier and DPO networks provided a competitive administrative rate. The same services are provided in both networks, but the reimbursement mechanism is different. Premier counties pay a fee-for-service competitive market rate. The DPO network is a high volume, discount program-the reimbursement rate is established by Delta Dental, and is less than the Premier rate. At the time of HKD's creation, approximately 90 percent of all dentists in Michigan were participating DeltaPremier dentists, while 20 percent of all dentists were DPO participants.

An additional 15 counties with DeltaPremier coverage were added to the demonstration program on October 1, 2000. On January 1, 2004, there were changes to the HKD program in the mix of Premier and DPO coverage. An additional four counties were converted from Premier to DPO counties due to budgetary constraints. As of June 2004, there are 29 counties offering Premier coverage and eight counties with DPO coverage.

Model Blueprint

Target Demographics

Any Medicaid-eligible person under the age of 21 living in one of the 37 participating counties can receive comprehensive dental benefits by general and specialist dentists through the HKD program.

Geographic Focus

The initial implementation of HKD included approximately 55,000 Medicaid-enrolled children in 22 rural counties of the state. The 15 additional counties, added four months later, brought approximately 45,000 more children into the demonstration program, for a total of nearly 100,000. As of June 2004, this demonstration program serves approximately 145,000 children.

Administrative and Organizational Structure of Program

Delta Dental Plan of Michigan (DDPM) administers the Medicaid demonstration program in the same manner as their traditional insurance program. As with private insurance plans, dentists directly submit claims to Delta Dental for processing and payment. Questions regarding eligibility and benefits are also directed to Delta Dental. Since both the Delta Premier and DPO have statewide networks, enrollees may go to any dentist who participates in the Delta Dental network in which they are enrolled.

Program Costs

With the change to HKD from the Medicaid-administered program, payments per enrolled member on a monthly basis increased approximately 250 percent (2.5 times). This higher cost is attributed to the increased number of users among those enrolled because of the increased availability of dentists, a shift in the mix of services to more comprehensive care, and the increase in provider reimbursement levels.

HKD is administered through a yearly contract between the Medicaid program and DDPM. The program pays DDPM an administrative rate per member based on a negotiated monthly rate. This rate has increased with each renewal of the contract. The fiscal year 2004 contract rate increased from \$12.64 to \$14.83 per member/per month. Since this is a no-risk contract, it is cost-settled at the end of each contract period. Payment is made monthly to DDPM based on the number of Medicaid beneficiaries under age 21 in the 37 respective counties. The rate is reviewed on an annual basis.

The Michigan legislature originally appropriated \$10.9 million to fund proposals designed to increase access to oral health services – half of that funding has been utilized to support the HKD program. Each year, the state must approve a budget to continue the HKD program.

Non-State/Federal Partners

The HKD program could not have been successfully planned and implemented without the cooperation of a broad array of interested stakeholders. The Michigan Primary Care Association, the University of Michigan School of Dentistry, Michigan Council of Maternal and Child Health and other public-private stakeholders, were instrumental in developing political support for the program. The dental profession in Michigan has been an essential and enthusiastic participant in the growth of the program.

Improvements in Program Financing and Administration

HKD payments range from 83 percent to 111 percent of dentists’ average charges in the East North Central region of the country (IL, IN, MI, OH, WI). The similarities among HKD payments and regional mean and median dentist charges suggest that the program’s payments are roughly equivalent to the fees charged by a very high proportion of general dentists in that region.

The administration of the program by a large private insurance carrier with extensive experience with dental insurance has notably improved the administration of the dental Medicaid program. Dentists already participating in DDPM programs were easily and seamlessly enrolled into the HKD program. Participating dentists did not have to learn new administrative procedures; instead, they were already accustomed to doing business with the DDPM.

The increase in participation by dentists and in utilization of services by eligible children has improved access to oral health care within the demonstration counties. HKD children are handled in the same manner as all other private patients. The larger number of participating dentists has eased the difficulties sometimes encountered by Medicaid beneficiaries in the past, such as finding dentists’ offices that would accept them. Participating dentists have also reported a reduction in missed appointment rates among HKD enrollees.

Dentist Participation Rates

During HKD’s first 12 months, 183 additional dentists who previously did not participate in the Medicaid program signed up to participate in HKD. Additionally, in the DeltaPremier counties, 85 percent of dentists who already participated in a private DDPM program also began to treat Medicaid-enrolled children through HKD.

The increase in locally available dentists also reduced the distance that HKD children had to travel for care, and as a result, the proportion of Medicaid-enrolled children who received dental care in their county of residence nearly doubled under HKD. Under the prior traditional dental Medicaid program, the average distance between the child’s residence and the treating dentist was 24.5 miles. Under HKD, this average distance was cut by more than one-half, to 12.1 miles—virtually identical to the average 12.2 miles traveled by the privately insured children in these counties.

Public Utilization Rates and Types of Services Received

A. Plan Utilization

The table below outlines changes in the percent of Medicaid-eligible children who had at least one dental visit within the 22 HKD counties – both before and after the counties were converted to the HKD program. The data identifies children who were enrolled for a full 12-month period and those who were enrolled for part of a year (1-11 month period). Within a relatively short period of time, for children enrolled for 12 months, the data represents a 39 percent increase in the number of children seen under HKD; and for children enrolled for part of the year, this represents a 55 percent increase of those seen under HKD.

Percentage of Children Utilizing Dental Care By Coverage and Study Period

Enrollment Duration	Before Healthy Kids Dental 22 Counties, April 1999 - March 2000	During Healthy Kids Dental 22 Counties, May 2000 - April 2001
12 Months	31.8	44.2
1-11 Months	11.1	17.2

B. Plan Coverage

The HKD program covers a broad range of dental services that are listed below. DDPM administers the services according to their administrative policies, which in some instances, may differ from the Medicaid program policy.

- Examination
 - Teeth cleaning
 - X-rays
 - Fluoride Treatment
 - Sealants
- Space Maintainers
 - Emergency Pain Treatment
 - Filling of cavities (as of October 2003, only amalgam restorations are covered for posterior teeth)
- Root Canals
 - Full and Partial Dentures
 - Stainless Steel and Resin Crowns
 - Extractions

C. Services Provided

At the commencement of the HKD program, Medicaid-enrolled children exhibited substantial need for dental services. The increased need for restorations and endodontics in the covered population was expected, given the previous low level of dental utilization. Within the first 12 months of the program, restorative and endodontic services made up nearly 45 percent of total expenditures for both HKD and traditional Medicaid enrollees, about twice the percentage of these services for the privately insured population.

On the whole, the program has not experienced a decrease in the utilization of restorative services. However, for those beneficiaries who have been in the program continuously, the need for restorative services has decreased-still above private market utilization but considerably lower than traditional utilization rates within the regular Medicaid program. Because there are new enrollees in the HKD program each month, restorative procedures continue to be utilized at a higher rate. The majority of the funds paid for the Delta Dental contract go to preventive and diagnostic (40 percent) and basic restorative services (40 percent).

Outreach to the Dental Profession and the Public

Dentists received announcements on the creation of the HKD program through the mail from DDPM. The Medicaid program in conjunction with DDPM and the Michigan Dental Association has also conducted focus groups in the HKD counties. During the focus groups, dentists were asked their opinion of the Medicaid dental program and the HKD program, their reasons for participation or no participation, their satisfaction with HKD as a program, and the administration by DDPM. The focus groups were held to allow dentists to have input into the program, to ensure the continuance of provider satisfaction or address provider concerns, and encourage additional provider participation.

The professional relations division of DDPM provides personal contact or support to respond to participating dentists’ inquiries concerning the HKD program. DDPM also provides a booth at the annual state dental association meeting where dentists can receive information about the HKD program.

Through their contract with the state, DDPM conducts an annual beneficiary satisfaction survey and publishes newsletters directed to HKD enrollees, providing updates on the program along with other timely oral health information on such issues as: how snacks and soda affect your oral health; when to take your child to the dentist; and appropriate oral home care and oral hygiene.

Endnotes

Eklund, SA, Pittman JL, Clark SJ. Michigan Medicaid’s Health Kids Dental program: An assessment of the first 12 months. JADA 134:1509-1515, 2003.

Berthold, M. Access leaps in Michigan: Healthy Kids Dental shows “substantial improvements.” *ADA News*, August 5, 2002.

Healthy Kids Dental 12-Month Assessment. http://www.michigan.gov/mdch/0,1607,7-132-2944_5327-36749--,00.html.

Health Kids Dental, Delta Dental Plans of Michigan. <http://www.deltadentalmi.com/programs/hkd/>.

Contacts

Ms. Christine Farrell
Program Specialist
Michigan Department of Community Health
P.O. Box 30479
Lansing, MI 48909-7979
517-335-5129

State Access Reform - Model 2

Medicaid Managed Care - Dental Carve Out

Introduction

This model represents a state Medicaid managed care program that chose to carve the dental program out of its ongoing (managed care) program and administer the benefit through a single dental plan administrator on a fee-for-service basis. Many states have turned to medical managed care organizations (MMCOs) to operate their Medicaid programs, believing that the competition between multiple companies will help manage services and control costs. Unfortunately, in many instances, these goals have not been met in the dental programs within Medicaid managed care. MMCOs generally have very little expertise in processing dental claims. There is no consistency in plan administration with multiple MMCOs, which creates confusion and frustration within the dental office. All too often in these arrangements, the majority of the budget allotted for healthcare is consumed by the medical plans. This leaves other aspects of health care, including dental, underfunded for the needs of the program. The concept of “carving out” aspects of health care from the overall budget is an action that ensures individual programs will receive their own allotment of budgeted dollars. The introduction of a single dental plan administrator allows for consistency in plan organization and administration. The process is further improved by the presence of an administrator whose focus and experience is in the administration of a dental program.

Sample Program

In January 1994, Tennessee made history by withdrawing from the traditional Medicaid program and implementing a statewide health care reform plan called TennCare. The vision of TennCare was to operate as a statewide Medicaid managed health care program. Care was to be coordinated and organized so Medicaid-eligible Tennesseans could get the right services in the right amount of time. This was to be accomplished through risk sharing and partnering with financially sound insurance contractors with strong provider networks for service to the population.

In 1984, prior to TennCare, over 1,700 dentists participated in Tennessee’s Medicaid program and this number continued to drop. The traditional state-run dental Medicaid program was failing to meet the needs of dentists. Even with the initial adoption of TennCare and the introduction of the MMCO’s, the number of participating dentists continued to decline. In 2002, there were fewer than 386 dental providers, including generalists and specialists, available to treat more than 600,000 TennCare-eligible children in the state. The program was troubled by administrative hassles and financial disincentives for dentists as a result of the multiple MMCO environment. Managing the eligibility of patients between multiple MMCOs only served to worsen the confusion and frustration of dentists.

In 2002, through the combined efforts of local dentists and the Tennessee Dental Association, state legislators passed legislation that carved the dental program out of the overall managed health care program. This program was required to meet all federal Medicaid requirements, and as such, did not require a federal Medicaid waiver for adoption. A Request for Proposals for a dental benefits manager was developed and released by the state, requiring the selected contractor to design and administer the dental insurance plan and increase the utilization of the plan. In October 2002, TennCare entered into a three-year agreement with Doral Dental of Tennessee to meet these requirements. The state also decided to increase their overall investment in the dental program, increasing reimbursement rates to dentists.

Model Blueprint

Target Demographics

The TennCare dental carve out program is directed at improving the dental health of eligible children under the age of 21. Children are considered eligible for TennCare if their family income is below 200 percent of the federal poverty level.

Geographic Focus

The TennCare dental carve out program is state-sponsored and operated statewide.

Administrative and Organizational Structure of Program

The state has entered into a no-risk administrative services contract with Doral Dental of Tennessee, LLC to manage the TennCare dental program. Administration of the program includes establishing provider networks and handling claims processing and benefit management.

Program Costs

The dental carve out/single administrator model is designed to work within the state's budget, which is determined by the state's legislature. Funding for the program is not guaranteed, and is addressed within each annual budget cycle. It is estimated that the dental program represents about four percent of the total state budget for TennCare.

Non-State/Federal Partners

While local dentists, the Tennessee Dental Association and state legislators were instrumental partners in establishing the dental carve-out program and in encouraging the state to increase dental Medicaid reimbursement rates to competitive levels, several other groups partnered together in support of these efforts. In 2001, through the leadership of the National Governor's Association (NGA), TN stakeholders met at an NGA-sponsored conference in Nashville to develop a state oral health access plan. Stakeholders in attendance included:

- Office of the Governor
 - Tennessee Department of Health
 - Bureau of TennCare
- Tennessee Health Care Campaign
 - Tennessee Dental Association
 - Tennessee Primary Care Association

Improvements in Program Financing, Administration and Case Management

Prior to the carve-out of the dental program under TennCare, each managed care organization individually negotiated dental reimbursement rates with dentists, and it is estimated that dentists were paid on average about 40 percent of their cost for each dental procedure.

Since establishment of the dental carve-out, the state sets the reimbursement levels and has been able to increase dental Medicaid reimbursement rates to rates that target the 75th percentile of regional dental fees published in the 1999 ADA Survey of Dental Fees (fees that 75 percent of dentists in the East South Central region of the United States report they charge for a particular service). This was accomplished by reallocating dollars within the existing budget and through additional appropriations supplied by the legislature for the program.

The state legislature has the ultimate decision on fee schedule determination. Annual state appropriations determine the program budget to support the fee schedule. Several other measures also help to ensure fees remain at or near market-based levels. Doral, through its Utilization Management (UM)/ Utilization Review (UR) system, monitors fee submissions from participating dentists. The administrator has an incentive to maintain the integrity of the program, since participating dentists enter into a contractual agreement, which states that if the plan does not perform as promised, they can terminate their participation in the program.

Several traditional administrative concerns with the dental Medicaid program have been addressed as a result of the dental carve out and selection of a single administrator. Prior to the carve out, dentists had to determine the various benefit designs and billing processes administered by each active managed care organization. The carve out resulted in one fee schedule, one benefit design and a single point of reference for dentists.

Doral, in working with the state, has developed web-based patient eligibility and patient scheduling systems which allow dentists to have 24-hour access to this information via a secure website and an interactive voice response telephone system (IVR). State officials have removed preauthorization requirements on dental procedures that have little impact on overall program costs.

Dentists' electronic claims are accepted through clearinghouses, files from the dentist's own billing system or free of charge through the Doral website. As of 2004, more than 45 percent of all TennCare dental claims are filed electronically, which has increased claims processing efficiency and accuracy resulting in prompt payment to the dentists.

As a result of improved reimbursement and administrative improvements, the dental network has expanded by nearly 80 percent. As a result of greater dentist participation in the TennCare program, patient travel time to the dentist has decreased significantly - average distance from an enrollee to a participating dentist is approximately four miles.

Patients are able to locate any general and specialist dentist within any area of Tennessee 24 hours a day every day through the IVR system. Doral customer service representatives also utilize a Geo-Access mapping program to link member zip codes with the nearest dentist who accepts TennCare referrals.

Dentist Participation Rates

An aggressive dentist recruitment campaign was initiated upon establishment of the dental carve-out; all licensed dentists in the state received a letter of introduction, a provider application, a provider service agreement, a W9 form and a return envelope. The state was divided into three regions and a lead recruiter was selected for each region. Dentists participating in the dental carve-out were also asked for testimonials and permission to use their names as contacts for other dentists considering participation in the program.

Participation rates in the TennCare program have increased dramatically since the dental carve-out and increase in reimbursement. The dental network has nearly doubled, growing from 386 dentists before October 2002 to approximately 700 dentists as of June 2004. By adjusting Medicaid reimbursement rates to levels consistent with the dental market and improving plan administration, the state has also been able to expand the geographic distribution and availability of dentists in the dental TennCare program. An estimated 25 percent of all practicing Tennessee dentists are actively participating in the program and 86 percent of participating dentists are accepting new patients, indicating additional capacity within Tennessee's existing dental network.

Public Utilization Rates and Types of Services Received

Patient access in the TennCare program has risen from 24 to 47 percent. This level of access is approaching the range that is reported in the private sector, which ranges from approximately 50 to 60 percent in Tennessee.

The oral health services provided through the dental carve out are comprehensive, and have not changed from the former dental TennCare program. Since the carve-out was established, there has been an increase in the number of dental treatment services provided, which is associated with the previous unmet dental needs and increased patient demand for services.

Outreach to Dental Profession and the Public

TennCare and Doral Dental have built a positive relationship with the Tennessee Dental Association and local dental societies. A Dental Advisory Committee was established to work with the state dental director and Doral Dental on such issues as plan administration and peer review. Doral's professional relations staff provide outreach to Tennessee dentists, providing assistance in program enrollment, billing and policy inquiries, technology support and practice management issues. Seminars are conducted on practice management topics and Doral participates in dental education programs in conjunction with the Tennessee Dental Association. A provider newsletter, communicates practice management tips, and any changes to program policies and procedures to all participating dentists.

Educational information is provided to TennCare enrollees through a member handbook and quarterly member newsletters. The program is also working cooperatively with a wide variety of community-based organizations, including:

- National Healthcare for the Homeless Coalition
 - Nashville Taskforce on Immigrants and Refugees
 - South Central Head Start Advisory Board
 - Tennessee Commission on Children and Youth
- Boys and Girls Clubs
 - Nashville Social Services Club; and
 - BlueCross BlueShield Member Advisory Panel.

Contacts

Mr. David Horvat
Executive Director
Tennessee Dental Association
615-383-8962

Dr. Tom Underwood
Chairman
Tennessee Dental Association, TennCare Committee
615-383-5366

Dr. Jim Gillcrist
Dental Director
TennCare
615-253-5398

Dr. Fred Tye
Dental Consultant
Doral Dental USA
800-417-7140

State Access Reform - Model 3

State-Administered Dental Medicaid Program And Targeted Case Management Program

Introduction

Several states manage the daily operations and administration of their dental Medicaid programs themselves, using state-supported staff and resources. These programs operate on a fee-for-service basis, and dentists submit payment requests or other billing-related inquiries directly to the state. State-operated dental Medicaid programs can be effective, if the state takes three central steps:

- Address administrative concerns within the program, including cumbersome billing procedures or prior authorization requirements. States that have successfully operated their own programs have realized that an effective program is one that is administered in a manner that is no more complex than private and commercial dental benefit programs.
- Establish market-based dental fee schedules and payment practices.
 - Improve consumer outreach and care coordination-targeting children and families most in need of oral health education, prevention, and treatment and behavioral intervention.

Successful state-operated dental Medicaid programs are not always easy to establish. As with any successful program, a coalition or team of stakeholders committed to developing and improving a program must be in place.

It is also an effective strategy to obtain a resolution or statement from the state legislature and the governor that urges public awareness of the importance of dental care and encourages state agencies, private practitioners and associations to seek solutions aimed at overcoming dental access barriers.

Sample Program

The Alabama dental Medicaid program is a state-run program administered on a fee-for-service basis by the Medicaid agency, and in 2000 was improved to reimburse dentists at levels that mirror commercial insurance rates. The state uses non-traditional approaches and innovative strategies to ensure access to dental care for those served by Medicaid. In response to low dental utilization rates within the Medicaid population and low rates of dentist participation in the program, the state established and began funding a dental outreach initiative called “Smile Alabama!” Gov. Don Siegelman announced the creation of this initiative in October 2000 after a legislature-supported resolution highlighting the importance of access to dental care was approved in April 2000. Smile Alabama! has resulted in significant improvements in the traditional dental Medicaid program.

“Smile Alabama!” is the outgrowth of a public-private collaboration between the Alabama Medicaid agency, the Alabama Dental Association and several community partners. A dental task force, involving the Medicaid agency was originally established in January 1999, followed by the creation of a dental partnership workgroup in March 2000. The workgroup began by surveying participating Medicaid dentists to identify barriers they were facing, which was followed by a survey of Alabama Dental Association members. Through these efforts, the workgroup identified the following key barriers to dentist participation:

1. Dental reimbursement rates
 2. Claims processing procedures
3. Lack of patient outreach
 4. Lack of provider outreach.

“Smile Alabama!” is funded by the state and grant funding support from the Robert Wood Johnson Foundation’s *21st Century Challenge Fund* (a component of the Southern Rural Access Program). The program has two central goals:

- Increase the number of dentists participating in Medicaid by 15 percent.
- Increase the number of children receiving dental care by 5 percent.

Model Blueprint

Target Demographics

Three different populations were targeted for initiatives within “Smile Alabama!” The first target population is patients being served. As of 2004, the state covers nearly 440,000 children through Medicaid (enrolled individuals below the age of 21) within the state.

The second target population is the caregivers, practicing dentists. Of this community, “Smile Alabama!” specifically targeted all general dentists, pediatric dentists and oral & maxillofacial surgeons.

The third target includes community partners-Head Start programs, maternity care coordinators, family medical practitioners, obstetricians and elementary school nurses. Each of these partners interacts with Medicaid beneficiaries and can assist in providing oral health awareness and linking those beneficiaries to a dentist.

Geographic Focus

While the entire state is a beneficiary of the “Smile Alabama!” program, rural counties with only one or no enrolled Medicaid dentists were specifically targeted for intensive recruitment and retention initiatives. Nineteen of the state’s 67 counties fell into this category. All 19 counties have populations below 100,000, while 14 of those counties have populations of less than 25,000 individuals.

Administrative and Organizational Structure of the Program

The Alabama Medicaid Agency administers the dental Medicaid program using a fee-for-service delivery system. The state has a contract with a fiscal agent (Electronic Data System – EDS) to handle several administrative functions of the program – addressing billing problems or questions, issuing payment to providers, and addressing provider enrollment concerns.

Program Costs

In announcing the “Smile Alabama!” initiative in October 2000, the governor committed \$6.5 million in state funds to raise dental Medicaid reimbursement rates. A combination of \$1.5 million from both private and public sources has been used to support the various consumer outreach activities within “Smile Alabama!”

Non-State/Federal Partners

Many groups partnered with the Agency to develop and implement “Smile Alabama!” in an effort to strengthen the dental Medicaid program. The Alabama Dental Association has worked with the Medicaid agency to provide information on the dental program during the Association’s annual meetings and through the association’s newsletter, and distributed information to its members from the agency, detailing changes in dental reimbursement fees and other programmatic changes to encourage dentist participation in the Medicaid program.

Another instrumental partner has been the Robert Wood Johnson Foundation’s *21st Century Challenge Fund*, which provided the program with an initial grant of \$250,000 to institute the outreach activities. An additional \$250,000 was contributed by grant partners providing a total of \$500,000 for the state match that allowed the Medicaid agency to pull down federal administrative matching funds of \$500,000.

Additional program partners include:

- Governor’s Office (Partnership/Coalition member)
 - Children’s Health Systems of Alabama (Partnership/Coalition member)
 - Medical Association of the State of Alabama (Partnership/Coalition member)
 - Alabama Dental Society (Partnership/Coalition member)
 - Children’s Rehabilitation Services (Partnership/Coalition member)
 - University of Alabama School of Dentistry (Partnership/Coalition member)
 - Alabama Hospital Association (Partnership/Coalition member)
 - Blue Cross/Blue Shield of Alabama (Partnership/Coalition member)
- Alabama Academy of Family Physicians (Partnership/Coalition member)
 - Alabama Academy of Pediatrics (Partnership/Coalition member)
 - Alabama Arise (an advocacy group for low-income families) (Partnership/Coalition member)
 - Alabama Primary Health Care Association (Partnership/Coalition member)
 - Alabama Department of Human Resources (Partnership/Coalition member)
 - Alabama Department of Public Health (Grant)
 - University of Alabama at Birmingham (Grant)
 - Alabama Power Foundation, Inc. (Grant)
 - West Alabama Health Services (Grant)

The number of partners has since expanded and become the Oral Health Coalition of Alabama (OHCA) with more than 30 member groups and organizations.

Improvements in Program Financing, Administration and Case Management

Since October 2000, dental Medicaid services have been reimbursed at 100 percent of the year 2000 Blue Cross/Blue Shield (BCBS) rates (with the exception of seven codes initially paid at 70 percent of BCBS pending development of sufficient auditing capabilities). BCBS is the predominate third-party dental carrier in Alabama.

In FY 1999, prior to the rate adjustment, the agency estimated it paid 54.7 percent of billed dental charges (e.g., for every \$100 of billed procedures submitted the Agency paid dentists \$54.70 – reductions based on allowable reimbursement vs. actual billing, eligible procedures for reimbursement, etc.). Calculations for 2002 place that percentage at 84.5 percent of billed charges.

As a result of statewide budget cuts in late 2003, it was anticipated that dental reimbursement rates would be reduced by two percent across the board. These cuts did not occur. Overall payments to dentists have increased from \$10 million in 2000 to over \$45 million in 2003. Reimbursement rates depend on continued state funding support for the program, which is appropriated on an annual basis.

Medicaid-specific procedure codes have been replaced by the current ADA *Code on Dental Procedures and Nomenclature* codes. The Medicaid Provider Manual has been updated to better define what is covered and outline program limitations. Procedures requiring prior authorization are clearly identified in the revised manual, and crowns have been removed from the procedures requiring preauthorization. Dentists are provided assistance in addressing billing and other administrative concerns through the state fiscal agent, EDS.

The agency adopted a new, simplified claims processing system. A critical component of the program is electronic claims submission. To encourage electronic claims and explain the system to enrolled dentists, the agency contacted each participating dentist to schedule a meeting and review changes and improvements. As a result, in 2002 paper claims submissions dropped 50 percent from 1999. Implementation of the revised submission process has seen the average number of days that lapse between a procedure being performed and then submitted for payment drop from 32.17 days in 1999 to 18.18 days in 2002. The agency estimates the average payment processing time as of June 2004, to be less than eight days.

Targeted case management through the agency's "Patient 1st" program was implemented in January 2001 based on recommendations from the dental task force and partners. This program matched patients identified by their dentists as potentially benefiting from intensive case management with licensed caseworkers who were social workers and nurses retained by the agency in the county of residence. The "Patient 1st" program was terminated at the end of February 2004 due to state budget cuts. Case management services remain but are now provided as a component of Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) care coordination.

Dentists may refer patients for case management for a number of reasons, including: non-compliance with dental treatment protocols; inappropriate behavior in the dental office; missed appointments; lack of ability to follow a care plan; language or educational barriers; or risk-taking behaviors. To refer a patient, the dentist contacts the Alabama Department of Public Health's case management service for the appropriate county. The patient's physician may also refer the individual for dental case management services.

Among the services provided by caseworkers are:

- Home visits or community follow up.
- Patient education or support.
- Tracking and follow up of children who frequently miss appointments.
- Coordination of services for patients with multiple caregivers and/or complex needs.
- Crisis intervention.
- Resource assistance.

Dentist Participation Rates

Up from a total of 441 enrolled dentists in 2000, 649 dentists were enrolled as Medicaid providers at the end of 2003. That represents an increase of 47.2 percent from 2000. This growth has been steady since the implementation of "Smile Alabama!" As of Spring 2004, there were 674 enrolled dentists.

Nineteen counties across the state with none or only one enrolled dentist as of 1999 became the focus for special recruitment activities. As a result, in 2002, that number had been reduced to 10 counties (all of which have populations of under 50,000).

Public Utilization Rates and Types of Services Received

Prior to implementation of the Smile Alabama! program and other dental Medicaid improvements, in 1999, 82,612 of the eligible population of 317,214 children received dental Medicaid services, a 26 percent dental visit rate.

In 2003, after programmatic improvements, 151,581 of the 436,170 eligible patients received dental Medicaid services, a dental visit rate of 34.8 percent. This represents an increase in the annual dental visit rate, even during a period where the eligible population grew by 37.5 percent. As of 2004, 96 percent of the children with a dental visit received preventive services, while 49 percent received restorative services.

Outreach to the Dental Profession and the Public

The Medicaid agency has enlisted the assistance and support of the Alabama Dental Association (ALDA) in developing, implementing and promoting changes to the dental Medicaid program. Since 2000, the agency has participated in ALDA meetings and professional workshops, created a newsletter for enrolled dentists, and revised and developed new materials for provider support that include posters, postcards, patient contracts, published fee schedules and patient videos. Most of this information is made available to dentists through the agency's website.

The program has relied on a significant "face-to-face" factor in the recruitment and retention of dentists. Agency staff is one component of the initiative with dental outreach specialists scheduling appointments with dentists to discuss the program with them on a one-to-one basis.

The agency also established a "Dental Ambassadors" program. Dental Ambassadors are Medicaid-participating dentists who assist in the recruitment and retention of dentists and also serve as spokespersons for Smile Alabama!

Both patient awareness/education and public awareness campaigns have been a significant part of Smile Alabama! An extensive public awareness effort wove patient awareness messages into the campaign. Included were the development and distribution of patient contracts, videos and other educational material for dentists to deliver to patients. The state Medicaid patient contracts detail both patient rights and responsibilities. The patient is required to sign the contract and acknowledge that should the patient break appointments, not follow instructions or the Medicaid rules, the dentist then has the right to no longer treat that patient. Additionally, a patient agrees that should that individual or someone who accompanies them act in a manner considered rude, mean or threatening, the patient may, as a result, lose their Medicaid coverage.

These activities are supplemented by radio and television ads (public service announcements) that stress the importance of early oral health care, keeping dental appointments and that only children with appointments should be brought to the dental office. After the success of the initial one-year media campaign, an additional year of radio and television announcements aired.

In addition to increased participation at health fairs and related events, the Agency has worked to provide materials and education to Head Start programs and school nurses across the state. As of fall 2003, over 1,500 Head Start oral health classroom kits entitled "Healthy Teeth, Healthy Mouth, Healthy You!" were distributed, reaching the more than 17,000 Head Start enrolled children. At the same time an obstetric/prenatal kit was developed and distributed to encourage physicians to begin early education about oral health with expectant mothers. Agency maternity care coordinators deliver brochures entitled "Taking Care of Baby's Teeth" to mothers during prenatal visits. Additionally, a kit was developed and distributed to Medicaid-enrolled pediatricians, family practitioners and dentists titled "1st Look," focusing on oral health anticipatory guidance and risk assessment with referral to a dentist based on the determined risk of oral disease. The Alabama Medicaid Agency continues to assess the needs of its population, working with the Dental Task Force and Oral Health Coalition to identify possible interventions to improve access to oral health care in the state.

Endnotes

Alabama Medicaid Website, *Smile Alabama! Medicaid’s Dental Outreach Initiative*, May 24, 2004, <http://www.medicaid.state.al.us/Dental/dental.htm>.

Greene-McIntyre, M, Finch, MH, & Searcy, J. (2003). Smile Alabama! Initiative: Interim Results From a Program to Increase Children’s Access to Dental Care. *Journal of Rural Health*, 19(S), 407-415.

Contacts

Mary G. McIntyre, MD, MPH
Medical Director
Alabama Medicaid Agency
501 Dexter Avenue
Montgomery, AL 36103
334-353-8473

Mr. Wayne McMahan
Executive Director
Alabama Dental Association
836 Washington Avenue
Montgomery, AL 36104-3839
334-265-1684

Community Access Reform - Model 1

Private Contraction with the Dental Safety Net

Introduction

Contracting between private sector dentists and health centers (e.g., federally qualified health centers [FQHCs] and FQHC “look-alikes”) is an option that allows the individual dentist to negotiate the terms of his or her involvement in providing dental services to health center patients, either in the dentist’s private office or in the health center facility. In September 2003, the Connecticut Health Foundation published a *Contracting Handbook and Model Contract*,²⁵ providing an outline of how such contracting arrangements can be organized and the legal and regulatory requirements concerning these arrangements. The Children’s Dental Health Project (CDHP), a non-profit advocacy organization served as the lead investigator and author for the publication.

Private contracting is based on the understanding that the private dental care delivery sector is far more robust than the public sector (safety net) and that many safety net facilities lack dental programs or personnel. The publication of the handbook is the beginning of efforts to link the resources of private dental practices to the needs of health center clients.

Sample Program

After publication of the Contracting Handbook, the Foundation awarded a grant through which the Connecticut Primary Care Association and the CDHP recruit health centers and dentists to engage in contracting and providing technical assistance. Contracting arrangements between dentists and health centers is a new concept and has not been implemented on a broad basis to allow for the selection of a specific model program.

Model Blueprint

Target Demographics

The contracting program is targeted at patients served by health centers when dental care is needed and beyond the capacity of the local health center.

Geographic Focus

The contracting model is potentially applicable in every state. It can be implemented anywhere that a federally qualified health center or federally recognized “look-alike” health center exists. While the contracting arrangement is designed for FQHCs and their “look-alikes,” it has the potential to be applicable to other health centers, including those that are organized under local governments or charitable organizations.

²⁵ <http://www.cthealth.org>. Developed for the Connecticut Health Foundation by Dr. Burton Edelstein, Children’s Dental Health Project. *Increasing Access to Dental Care Through Public/Private Partnerships – Contracting Between Private Dentists and Federally Qualified Health Centers*. September 2003. The model contract is intended for reference. State legal requirements do vary and both dentists and health centers should consult with their attorneys prior to entering into such a contract.

Administrative and Organizational Structure of Program

The contracting model can be implemented by any individual dentist and/or any appropriate health center executive without additional administrative or organizational program support. However, successful marketing and replication of the program by interested entities, including local dental societies, state primary care associations, health or social foundations, dental schools, and state or local health agencies, could encourage its widespread use.

Program Costs

The state does not directly finance the contracting arrangements and no legislative appropriation is involved. Under the contract arrangement, the health center and dentist negotiate payment rates to dentists for the provision of specified dental services to specific health center patients. The underlying payment resource is the totality of funding streams available to the health center. Typically, the most significant source of payments to health centers is Medicaid, which pays FQHCs on a prospective payment arrangement resulting in a payment per visit rate. Each center individually negotiates such a visit rate with its state Medicaid authority. FQHCs also receive direct federal grants (330 grants) for care of the uninsured and many also obtain additional funding from community, philanthropic and private sources. The legal prohibition inherent in such contracting is that the FQHC cannot directly pass on its Medicaid visit payment rate to the contracting dentist. However, any other payment arrangement that meets the needs and interests of the two parties is allowable (e.g., payment on a fixed fee schedule by procedure; payment on a per-patient basis; payment on a per-visit basis; or payment on a per-session basis in which more than one visit is scheduled).

Non-State/Federal Partners

The following organizations serve as resources for dentists, health centers and state officials who are interested in establishing private contract arrangements:

- The Connecticut Health Foundation, which sponsored the project as part of its oral health initiative.
- The American Dental Association and its component, the Connecticut State Dental Association, which reviewed the concept and handbook from the dentists' perspective and has endorsed the creation of such contracting arrangements.
- The Children's Dental Health Project which investigated the management of a contract arrangement through federal and other regulatory bodies, and provides ongoing technical assistance for its implementation.
- The National Association of Community Health Centers and its Connecticut affiliate, the Connecticut Primary Care Association, which conducted extensive review of the model contract agreement.
- The Connecticut Appleseed Center for Law and Justice, an association of attorneys whose "mission is to build a just society through legal advocacy, community activism, and policy expertise."

Improvements in Program Financing, Administration and Case Management

Because the fee arrangement between the dentist and health center is negotiated between both parties, it represents a market-based arrangement. Health centers have financial constraints that they and their dentist-partners must recognize, particularly since they are legally responsible for caring for all, regardless of patients' ability to pay for services. However, Medicaid visit rates awarded to health centers are typically higher than comparable fee-for-service rates paid by Medicaid directly to dentists. For this reason, the health centers have some latitude, and depending on their finances, are able to establish rates that are different from Medicaid fee-for-service payments. In addition, dentists may contract with a health center based on time, patients, or types of dental services, thereby allowing significant flexibility within the contract arrangement.

One suggested way to establish a contracting relationship is for the dentist to identify a block of time (e.g., a half day on alternate weeks) to contract for the care of health center patients at a fixed session rate. Similarly, dentists may arrange a contract to provide care to a specific number of patients per month based on a fixed payment for each visit. Contracting options are varied and depend solely on the mutual interests of both parties. Notable, however, is that under such an arrangement, the health center alone is at financial risk (e.g., incurring expenses at levels greater than their underlying resources can provide) as the dentist is guaranteed payment for patients seen.

Under contracting arrangements, dentists do not need to be Medicaid providers in order to treat health center patients, including those covered by Medicaid. The health center is directly responsible for billing the private dentists' services and the health center is responsible for paying the dentists for services rendered. Also, the patients do not officially become patients of the dentist's practice, as they remain patients of the health center.²⁶

Only those patients who require the kinds of services that the dentist has contracted for are referred by the health center. In most cases, it is the health center that provides the case management, appointment scheduling, and transportation guidance to the patient. Dentists, however, must honor health center administrative requirements including (a) credentialing and (b) acceptance of the health center's patient grievance procedures, as these are federal requirements that pertain to the center.

Dentist Participation Rates

Few dentists can be expected to engage in a private contracting program with health centers without being solicited unless they are strongly motivated as individuals to see the underserved. Also, health centers are not likely to aggressively market this approach as it carries some financial risk to them. As a result, its implementation depends upon a promotional agent within the state or community to raise awareness of this option. In Connecticut, the Connecticut Health Foundation assumes this role. In other locales it could be, for example, a local dental society, a foundation, an oral health coalition or workgroup, or a public or private social service agency.

Contacts

Dr. Burton Edelstein
Children's Dental Health Project
1990 M Street, NW, Suite 200
Washington, DC 20036
202-833-8288
ble22@columbia.edu

Ms. Pat Baker
President and CEO
Connecticut Health Foundation
270 Farmington Avenue, Suite 331
Farmington, CT 06032
860-409-7774
pat@cthealth.org

²⁶ This does not diminish the professional responsibilities of the dentist.

Community Access Reform - Model 2

Community-Funded Dental Practices

Introduction

One innovative approach toward improving access to oral health care for communities in need is to have community partners work together to establish a freestanding, fee-for-service, for-profit, private dental center. Such a center is possible if support is provided to help subsidize practice costs (e.g., allow for a discounted lease/rental of dental office space and equipment through a contract between a not-for-profit community-based organization and a private practice dentist). At least one state has explored this option, supporting a dental practice in return for the dentist's commitment to treat a specified volume of Medicaid patients. Though the primary goal of this type of model is to provide comprehensive oral health care for Medicaid beneficiaries, the practice also provides care to the uninsured, those with private dental insurance and private pay patients.

The uniqueness of this model stems from its diverse community partners. These partners coalesced into a community-based organization that created a dental practice to stem the tidal wave of patient demand within a specific community for oral health services, resulting when the state increased Medicaid eligibility rates to 300 percent of the federal poverty level. At the same time, the community lost its main local Medicaid provider-a dental clinic operated by Kaiser Permanente. Because the dedicated community leaders understood the disproportionate burden of oral disease in Medicaid beneficiaries, there was an intense commitment to increase dental care capacity for low-income families, especially the children in the local Head Start program and in elementary schools. Increasing public awareness, facilitating outreach to all sectors of the community and occasionally providing input on business management issues are ongoing contributions of an advisory committee.

Under this state model example, ongoing practice revenues are solely derived from fees paid by patients, private dental benefit plans and from Medicaid. This model is ideal for a community with a coalition interested in developing and helping to sustain a unique fee-for-service dental practice that will not be as vulnerable to public funding cycles. Further, it has the significant advantage of creating market driven incentives to succeed without constant oversight or operational funding. The guiding philosophy of this dental practice is consistent with other private dental settings – comprehensive care consistent with the patients’ needs and wishes. The practice and its partners work hard to connect oral health to general health as well as to deemphasize, and counsel patients to avoid, unhealthful cycles of critical and episodic oral health care.

Sample Program

Estey Dental Center in Brattleboro, Vermont went into business in 2000. It operates as a freestanding, for-profit dental office in a Vermont community of 13,000 citizens. The model was conceptualized by a group of community leaders to increase provider capacity to meet the oral health access needs of Medicaid beneficiaries, primarily children, when the state Medicaid eligibility level was dramatically increased with no local capacity to further expand dental services. At the same time, dental Medicaid reimbursement rates were either stationary or being cut. A local dentist wrote the business plan for an independent dental office and spearheaded a coalition of dentists, health care and school district officials that hired a local dentist on contract. The dentist's contract included primary first-year goals to provide comprehensive care for at least 900 child Medicaid beneficiaries each year, endeavor to care for their family units, and expand care to other adults. The operation has aspects of a publicly funded health center, such as an advisory committee and community outreach program, but receives no ongoing, sustained form of federal funding. To seed initial operational expenses, grant funding was received from the state, a community development block grant and from local private foundations. The clinic's success is evident because 1,050 Medicaid-eligible children received oral health care in the first 12 months of operation, exceeding its goal. After 22 months of operation, the Estey Center dentist brought in an associate and hired additional staff, including a dental hygienist, to further increase capacity.

Model Blueprint

Target Demographics

The primary demographic served by the dental center is Medicaid beneficiaries, particularly children. Children on referral lists from school nurses, the local Head Start grantee and a public health nurse were prioritized until waiting lists were cleared. The dental center endeavors to provide care to all Medicaid-eligible adults, especially parents of children in active treatment; however, adult dental services are limited as of 2004, in that they are subject to a \$475 annual maximum in Vermont.

Geographic Focus

The target area for this model is a rural, small town with a population around 13,000.

Administrative and Organizational Structure of Program

The dental practice is operated by a dentist, who is under contract with the local school district (as a 501c3) and an advisory committee. The advisory committee set up the practice, purchased equipment and managed leasehold improvements. The dentist's contract specifies that he is free to leave with 12 months notice and establish another local practice. If the dentist decided to leave the practice the advisory committee would hire a new dentist, and there is a plan in place for local dentists to take care of emergency patient needs in the interim.

The dentist manages all financial aspects of the business, and is required to submit a monthly check to the 501c3 (local school district and Head Start Program) equal to 7.5 percent of non-Medicaid practice revenues for each month. These funds are held in a reserve, which is overseen by the advisory committee. In the first few years, the fund generated between \$15,000 and \$20,000 per year. The reserve fund is used for practice expansion and new equipment. The dentist pays rent and hires, supervises and pays the office staff. The dentist also pays for insurance, supplies and utilities. As of 2004, two additional treatment rooms have been added to the practice for a total of five, using monies from the reserve fund and a grant from the Head Start program.

Program Costs

The state of Vermont provided a \$127,000 grant for initial equipment purchase. A community development block grant of \$232,000 and \$110,000 in grants from private foundations fulfilled clinic start-up cost requirements. Ongoing operational revenue and expenses are managed similar to other independent small businesses run by primary health care providers. The dentist is responsible for the cost of equipment repairs, supply inventory and other expenses. The dentist may, solely at his discretion, expand the staff by adding allied dental personnel or dentist-associates. The practice revenue and the dentist's income are dependent on patient services rendered and paid for, as in any for-profit dental practice.

Non-State/Federal Partners

The original plan for the dental center was conceived by a group of community leaders, which developed into an advisory committee, including:

- Local school officials
- Hospital administrators
- Local and state health department staff
- Head Start program staff

Improvements in Program Financing, Administration and Case Management

As a for-profit dental office, the dentist sets fees consistent with local market levels for private paying patients. The dentist has the responsibility of managing overhead expenditures and maintaining patient flow. The net profit is the dentist's income; there is no guaranteed salary level. In addition to stated minimum goals to provide comprehensive care for a specific number of Medicaid beneficiaries, the dentist provides care to other patients. There is a mix of about two-thirds Medicaid beneficiaries and one-third private paying patients in the dental practice.

The dental center model is a traditional dental practice that requires little government participation or community fundraising. Unlike publicly funded clinics that depend on government funding cycles, this dental center is able to financially sustain itself. The dentist works under contract and does not own the business in the traditional sense. If the dentist decides to leave, all equipment must be left in good working order and an inventory of supplies valued at \$30,000 must be passed on. There are other contractual requirements as well, such as ensuring moral and ethical conduct, maintaining professional liability insurance and meeting state Medicaid contract requirements.

Case management processes are characteristic of any independently owned primary health care business. At the dental center, families are strongly encouraged to bring young children in for a dental visit; this education begins when pregnant women are first seen by the dentist and is reinforced by community coalition members including public health nurses and well-child clinics. Patients receive continual information about appointment policies from center staff members. The clinic receptionist confirms all appointments directly with the patient. If an appointment is missed on two occasions without advance notice, the patient is encouraged to seek care from another provider. Dental hygiene appointments are booked closely together to allow for patients who fail to present for appointments.

Patient travel time to the dentist is not a concern because a source of care was retained in the community through the dental center. The community leaders realized that the farther families had to travel for dental care the less likely they were to seek it.

Dentist Participation Rates

Two other dentists in the town are Medicaid providers and that has remained unchanged since Estey Dental Center opened in 2000. In addition, because this model flourished, a second dental office using the same self-sustaining approach has been set up and operates 25 miles north of the original center.

Public Utilization Rates and Types of Services Received

State Medicaid data by county shows that between the fiscal years 2001 and 2003, during the first two years Estey Dental Center was in operation, unduplicated patient visits from Medicaid beneficiaries increased from 669 to 1,704 in the community. A huge backlog of children with acute and chronic dental needs was taken care of in those first two years, and as of 2004, utilization by children has leveled off. Adult utilization has also increased every year.

The practice has a philosophy of comprehensive treatment planning and caring for patients with the goal that they will be a patient of record forever. This philosophy is continually reinforced through patient education within the center and community, and has been well received by patients-very few patients seeking episodic care.

Outreach to Dental Profession and the Public

From its inception, both the state and local dental societies actively supported the creation of Estey Dental Center as a way to increase access to dental services within a community. The state dental society communicated its endorsement of the Center concept to dentists throughout the state so that any misunderstandings and questions could be quickly addressed. Members of the local dental society are on the Estey Dental Center advisory committee, so they are involved first-hand in the center's activities.

The Head Start program, local school system, local health department, local Department of Human Services, and the local hospital assist Estey Dental Center in reaching out to the public by referring patients to the center who need care and in educating their clients/families about the importance of oral health and links between oral health and general health.

Contacts

Dr. David Neumeister
1046 Western Avenue
Brattleboro, Vermont 05303
802-254-2384
neum1@sover.net



American Dental Association
www.ada.org

211 East Chicago Avenue
Chicago, Illinois 60611-2678